



MILWAUKEE COUNTY
Behavioral
Health
Division

myAvatar™

Tips and Tricks



Recovery Plan of Care-Outpatient

From the Home Screen, search for and select the client. With the client selected, enter Recovery in the Search Forms box. Double-click to select the Recovery Plan of Care Outpatient.

The screenshot shows the myAvatar interface. On the left, under 'Recent Clients', 'Iris Flower (008168942)' is highlighted. The main area displays a list of forms with columns 'Name' and 'Menu Path'. The form 'Recovery Plan of Care Outpatient' is highlighted in green. Below the list, there is a search bar with 'recovery' entered, and a 'Hy To Do's' section showing 'All (11)' items.

For a new client/plan, the form opens upon selecting the form (above). If the episode pre-display screen opens, select the appropriate episode of care and click OK.

Note- If the client has a previous Recovery Plan, a series of screens are presented that allow you to pull information forward from previous plans as needed. Follow the steps below to pull information forward from previous plans.

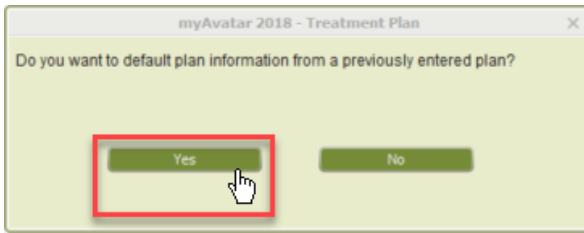
1. Select the appropriate episode and click OK.

The screenshot shows the 'Recovery Plan of Care Outpatient' form. The 'Episode' tab is selected, and a list of episodes is displayed. The episode '11' is highlighted. The 'OK' button is highlighted at the bottom.

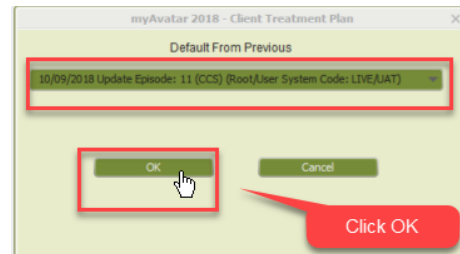
2. Select Add.

The screenshot shows the 'Recovery Plan of Care Outpatient' form. The 'Add' button is highlighted at the bottom.

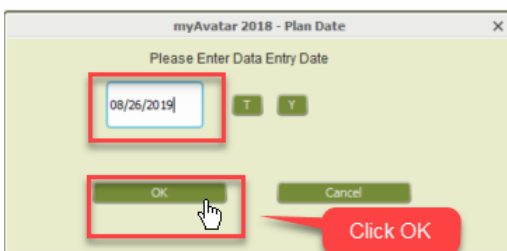
3. Select Yes to pull forward.



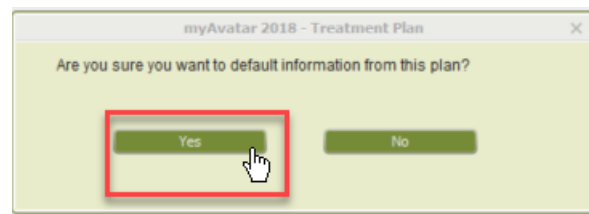
4. From the drop-down list, select the plan episode that you want to pull information from.



5. Enter the data entry date.



6. Select Yes to pull information forward.



The form opens in Draft status.

Please ensure that your department guidelines are being followed when completing this Recovery Plan of Care

Red, required fields must be completed before the form can be finalized. Items in black are not mandatory to complete. **However, always check with your Supervisor for individual program requirements.**

1. **Data Entry Date:** this is pre-populated with the date you open the form.
2. **Plan Start Date:** **mandatory field**- the date the Recovery Plan actually starts.
3. **Plan End Date:** set this date for 6 months after the Plan Start Date.
4. **Plan Type:** **mandatory field**- choices are Scheduled or Update. Generally choose Scheduled (3, 6, 12 month) recovery plan. Choose update to make plan changes (change the plan start date but leave the plan plan end date).
5. **Last Updated By:** this is pre-populated with your name.
6. **Last Updated:** this is pre-populated with the data entry date.
7. **Treatment Plan Status:** **mandatory field**- should be Draft while making edits. Electronic signatures cannot be obtained until the Status is listed as Final.

TIP Click this icon to Save the Form as a Favorite

1 Data Entry Date: 08/26/2019

2 Plan Start Date: 08/28/2019

3 Plan End Date: 02/28/2020

4 Plan Type: Scheduled

5 Last Updated By: Susanne Morris (Avatar User Experien

6 Last Updated: 08/27/2019

7 Treatment Plan Status: Draft

Concerns

Select each concern (problem) listed that should be included in the plan. Every concern you select will appear when the plan is launched. You must have at least one intervention for each concern included in the plan.
(*See below for additional information on this section.)

* The 'Concerns' section is populated from the Avatar Problem List. Additional concerns/problems can be added using the forms/steps below.

1. Complete the Diagnosis Form and select **Yes**, to 'Add to Problem List' at the bottom of the form.
2. Complete the Problem List Form.
3. Add a new row to the grid in the Concerns section.

To add a new row to the grid, use the steps below:

1. Select **New Row**.
2. **Problem-** **mandatory field**- click in the Problem field and enter a problem/diagnosis. Click Enter.
3. In the Search Results box scroll down to find the appropriate problem. Click Select.
4. **Other-** if you can't find a specific type of problem, use *Specify Other* for the Problem in #2 and enter a description in the **Other** text box. Click Ok.
5. **Type-** select the type of problem, Primary or Secondary. This is not required, but is populated when completing the Diagnosis Form in Avatar.

6. **Date identified-** indicate the date the problem was identified, as needed.
7. **Date of Onset-** **mandatory field**- indicate when the problem started. If the onset date is unknown, use the episode admission date.
8. **Status-** **mandatory field**- select an appropriate value from the drop-down list and click Select. Usually this is set to Active. If you Resolve a problem, indicate the date in column 9.
9. **Date Resolved-** enter the date the problem is identified as resolved. (See #8 above)

10. **Action-** for all Active problems, enter 'Treating' in this field. For other problems not included in the plan, enter a reason why the problem is not included in the plan.
11. **Problem Information-** this is an embedded link to Medline Plus, a website for additional health information.

Note- once you've completed the new row, be sure to go back and check, **Include in this plan?**, if this concern will be addressed in the plan.

Plan Participants- use this section to select all members participating in the plan, including the client. Click New Row/Delete Row as needed to add or delete plan participants.

1. **Role-** **mandatory field**- the role of the participant (i.e. Case Manager).
 2. **Staff ID-** depending on which role you chose, this field will either be required, or not. If you chose a role that refers to a person who has access to Avatar, then this field will be **mandatory**. When you start entering a name, (press tab), the provider's name will appear for you to choose it. If you've chosen a role that does not have access to Avatar, then you cannot type in this field. *(Ext) will jump to Participant name.
 3. **Participant Name-** will pre-populate if Staff ID was entered. If you were not able to choose a Staff ID, then you will need to enter the participant name in the text box.
 4. **Plan Author-** **mandatory field** - there can only be one Plan Author. This yes or no field answers the question, "Is the person in this role the Plan Author" (person completing the RPOC)?
 5. **Notification-** **mandatory field** – This yes or no field answers the question, "Is the person in this role a team member with access to Avatar that will review the plan at the next review date"?
- Note-** See notification workflow at the end of this section.
6. **Attended Plan Conference-** this is generally set to yes for each plan participant.
 7. **Signature-** all non-Avatar users will sign using the electronic signature pad. Members of the team will electronically approve, but only after the plan has been designated as final.
 8. **Declined to Sign-** only check this box on the consumers row and only if the consumer declined to sign.
 9. **Signed on Paper-** last resort option if signature pad is not working. If used, the signature/plan will need to be scanned into Avatar.

Notification Workflow (5) above

Each plan participant marked **Yes** in the 'Notification' section will receive a message on the 'My To Do's' widget 30 days prior to the next review date. This is a reminder to the recipient that the plan needs to be reviewed and updated in the next month.

1. The reminder will appear on the To Do widget and indicate the date the RPOC is due for review.
2. Clicking on the link in the Forms column will open the RPOC form; however, the form can only be reviewed as it is in Final status.
3. To review the To Do item, click the link in the Action column. A Review ToDo Item box opens for further actions (see step 4 for details).

The screenshot shows the 'My To Do's' application interface. At the top, there's a header bar with 'My To Do's', 'All (13)', and buttons for 'New (0)' and 'Sign (0)'. Below the header is a filter bar with 'Filter' and 'All'. The main area is a table with columns: Client, Action, Form, Sent, From, Comments, and Note-to-Send. The table contains 13 rows of tasks. Red callouts are used to highlight specific elements:

- Callout 1 points to the 'Quick View' icon in the top right corner.
- Callout 2 points to the 'Form' column header.
- Callout 3 points to the 'Action' column header.
- Callout 4 points to a specific row in the table, which is highlighted in green.

Client	Action	Form	Sent	From	Comments	Note-to-Send
	Review To Do Item	Individual Progress Note	03/27/2019	Susanne ...	Review Draft Progress Note For Episode 4	
	Review To Do Item	Individual Progress Note	04/09/2019	Patricia V...	total time not noted	
	Review To Do Item	Individual Progress Note	05/01/2019	Susanne ...	Review Draft Progress Note For Episode 3	
	Review To Do Item	Recovery Plan of Care Outpatient	06/25/2019	TEMPORA...	Recovery Plan of Care Outpatient " Is Due For Review On 07/25/2019	
	Review To Do Item	Recovery Plan of Care Outpatient	08/02/2019	Susanne ...	Draft Recovery Plan of Care Outpatient " For Reviewing	
	Review To Do Item	Individual Progress Note	08/06/2019	Susanne ...	Review Draft Crisis Mobile Team For Episode 3	
	Review To Do Item	Individual Progress Note	08/06/2019	Susanne ...	Review Draft Psychiatric/Psychological Assessment For Episode 1	
	Review To Do Item	Individual Progress Note	08/06/2019	Susanne ...	Review Draft Psychiatric/Psychological Assessment For Episode 1	
	Review To Do Item	Individual Progress Note	08/08/2019	Susanne ...	Review Draft Progress Note For Episode 1	
	Review To Do Item	Crisis Progress Note	08/13/2019	Susanne ...	Review Draft Progress Note For Episode 2	
	Review To Do Item	Recovery Plan of Care Outpatient	09/12/2019	TEMPORA...	Recovery Plan of Care Outpatient " Is Due For Review On 03/10/2019	
	Review To Do Item	Recovery Plan of Care Outpatient	09/12/2019	TEMPORA...	Recovery Plan of Care Outpatient " Is Due For Review On 10/12/2019	

4. A summary of the ToDo displays. To view a detailed report of the RPOC, click View Detail.
5. To mark the item as reviewed and **delete** it from the 'My To Do's' widget, select the Reviewed box and click Submit. Use caution as this action permanently deletes the message.
6. If you'd like to **keep** the reminder on your 'My ToDo's' widget, click the red X to exit the form.

Chart Review To Do Item

Review To Do Item

Submit

Recovery Plan of Care Outpatient ' ' Is Due For Review On 10/12/2019

Set To Do Item to Reviewed

☐ Reviewed View Detail

Online Documentation

Client Input- Fill out all appropriate sections as defined below.

1. Date the service planning process was explained to the consumer and, if appropriate, a legal representative or family member. **This is a CCS requirement.** The date listed here will have a case note to further explain. For TCM, this could meet Targeted Case Management medicaid handbook's requirement of documentation that the consumer has participated in the development of the the plan. The consumer's signature meets the requirement of the consumer agreeing to the treatment and service goals.
2. Launch Plan- When all information is complete, click Launch Plan. Selecting this button will bring you to the concern/goal/objective/intervention section of the Recovery Plan of Care.

▼ CLIENT INPUT

Strengths ⓘ

Strengths can be identified as skills, characteristics, attributes, interests, cultural influences, experiences, activities, environmental factors, natural supports, previous successful strategies that lend to success in life and are valued by the consumer. Strengths can be self-identified or identified by others.

Barriers ⓘ

Barriers/Needs may include the consumer's symptoms, behaviors, functional skill deficits, and resource needs that have a negative impact on a consumer achieving their life vision. What are a consumer's challenges/needs because of their mental health and/or drug use? They can be self-identified or identified by other team members.

Discharge Planning ⓘ

Discharge Planning is an interdisciplinary person-centered process which involves the team of formal and informal supports of the individual (including people in the individual's life). It is the initiating, coordinating and facilitating actions that occur to execute the discharge plan based on the person's needs and ongoing assessments throughout a person's inpatient stay and after discharge or discharge from an outpatient treatment program.

Life Vision ⓘ

Life's Vision is the consumer's personal long-term goal. It is an aspirational statement about what the consumer wants to achieve, and their personal vision of how they want their life to look. The life vision should guide the development of the recovery plan of care. The vision should be written in the consumer's language.

Discharge Criteria ⓘ

Discharge Criteria are the agreed upon requirements established by the individual and their treatment team to facilitate a safe and successful discharge from the hospital, outpatient treatment program or other community based program. Discharge criteria are integrated into the discharge plan, based on the needs identified through assessment and evaluation.

Comments

Additional comments as needed.

2

Launch Plan

▼

Date the service planning process was explained to the consumer and, if appropriate, a legal representative or family member

1 10/01/2019 Today Yesterday

Launch Plan

Use this section of the plan to address planned goals/objectives/interventions for each Concern/Problem checked on page 1 as, Included in the plan.

Concerns

1. Use the arrows to expand/collapse sections of the page for easier viewing.
2. Each concern checked (from plan page 1) as 'Included in the Plan' is listed. **Select the first concern** listed.
3. **Problem Code-** **mandatory field** - this pre-populates from plan page 1.
4. **Date of Onset-** **mandatory field** - this pre-populates from plan page 1.
5. **Concern-** **mandatory field** - this pre-populates from plan page 1, but can be revised. Consider editing this field to reflect language that is person-centered (i.e., George experiences both positive and negative symptoms of Schizophrenia including,) rather than simply defining a person by their diagnosis.
6. **Date Opened-** **mandatory field** – (Start Date) should correspond to the first time this specific concern is listed in the Recovery Plan.
7. **Staff Assigning-** this is the plan author.
8. **Other** – list other problem related information. This is grayed out when problem code pre-populates.
9. **Status (Problem List)** - **mandatory field** - this pre-populates from page 1.
10. **Status** – **mandatory field** – Active or Resolved. The problem should be Active until it is completed and then select Resolved. Once the problem is Resolved, all related interventions should be removed and enter the date the problem was resolved in, Date Closed.
(Predefined is not used and will always be checked no. Staff Responsible and date due are not mandatory. Check with your Supervisor for individual program guidelines.)
11. **Add New Goal** – with the Concern selected (highlighted) click *Add New Goal*.

Recovery Plan of Care Outpatient: TERRELL WIGGINS

Concerns: Worries (1)

Goal: (2)

Objective: (3)

Interventions: (4)

Concern: Adjustment disorder with depressed mood (5)

Problem Code: Worries (3)

Date of Onset: 04/25/2018 (4)

Concern: Worries (5)

Date Opened: 07/24/2019 (6)

Staff Assigning: SUSANNE MORRIS (010884) (7)

Date Closed: (8)

Predefined: No (9)

Other: (8)

Status (Problem List): Active (9)

Status: Active (10)

Staff Responsible: (11)

Date Due: (11)

Buttons: Add New Concern, Add New Goal, Add New Objective, Add New Intervention, Remove Selected Item

Speech Bubble: BHD is not currently using the Library and Filters functionality.

Add New Goal

1. **Goal-** **mandatory field**- enter the consumer's goal here.
2. **Date Opened** (Start Date)- **mandatory field**- enter the date the goal started.
3. **Status-** **mandatory field**- select Active or Resolved. Leave the goal Active until it is completed and then choose Resolved. Once the goal is Resolved, it should not have any active objectives/interventions. Enter the date the goal was resolved in, Date Closed. (Predefined is not used and will always be checked no. Staff Responsible and date due are not mandatory. Check with your Supervisor for individual program guidelines.)
4. **Add New Objective**- another goal for this concern can be added by clicking , *Add New Goal*. When the goal section is complete, click *Add New Objective*.

The screenshot shows a web form for adding a new goal. At the top, there are five buttons: 'Add New Concern', 'Add New Goal', 'Add New Objective', 'Add New Intervention', and 'Delete Selected Item'. The 'Add New Objective' button is highlighted with a red box and a red circle with the number 4. Below the buttons, the form has several fields: 'Goal' (with a sub-label 'Goal related to concern') is highlighted with a red box and a red circle with the number 1; 'Date Opened' (with the value '10/03/2019') is highlighted with a red box and a red circle with the number 2; 'Status' (with the value 'Active') is highlighted with a red box and a red circle with the number 3. Other fields include 'Date Due', 'Date Closed', 'Staff Assigning' (with the value 'MORRIS, SUSANNE'), and 'Staff Responsible'. At the bottom, there is a 'Predefined' section with 'No' selected and 'Yes' as an option.

Add New Objective

1. **Objective-** **mandatory field**- enter the consumer's objective related to the goal.
2. **Date Opened** (Start Date)- **mandatory field**- enter the date the objective started. It needs to match the 'start date' or 'updated date' of the plan.
3. **Status-** **mandatory field**- select Active or Resolved. Leave the objective Active until it is completed and then choose Resolved. Once the goal is Resolved, it should not have any active objectives/interventions. Enter the date the objective was resolved in, Date Closed. (Predefined is not used and will always be checked no. Staff Responsible and date due are not mandatory. Check with your Supervisor for individual program guidelines.)
4. **Add New Intervention**- another objective for this concern/goal can be added by clicking , *Add New Objective*. When the objective section is complete, click *Add New Intervention*.

Add New Intervention

1. **Intervention-** **mandatory field-** enter the planned intervention related to the goal/objective.
2. **Date Opened** (Start Date)- **mandatory field-** enter the date the intervention started. It needs to match the 'start date' or 'updated date' of the plan.
3. **Status-** **mandatory field-** select Active or Resolved. Leave the intervention Active until it is completed and then choose Resolved. Enter the date the intervention was resolved in, Date Closed. (Predefined is not used and will always be checked no. Staff Responsible and date due are not mandatory. Check with your Supervisor for individual program guidelines.)
4. **Frequency-** **mandatory field-** select how often the intervention will be completed.
5. **Instances-** **mandatory field-** select the appropriate number (elaborates on the frequency).
6. **Payment Source-** select the appropriate payment source (if chosen when a subsequent plan is started, this will pull forward from the initial plan).

Another intervention for this concern/goal/objective can be added by clicking , *Add New Intervention*.

7. All **Concerns** checked on the first page need to be addressed in the plan. Select the next Concern and repeat previous steps to add goals/objectives/interventions for each concern.
8. **Back to Plan Page-** when all concerns have been addressed and the plan is complete, select Back to Plan Page to finalize the plan.

Finalizing and Routing the Plan- from plan pg.1:

1. **Select Final** to move the plan to final status. **Note #2 below before moving plan to final status.**
2. **To Do Message-** this functionality enables the user to route the plan to another staff member for review **prior** to plan finalization. As needed, select the *To Do* icon and follow the instructions at the end of the tip sheet before finalizing the plan.
3. **Click Submit.**

1. Carefully review the document TIFF image. Use the arrow keys to page forward and backward through the document.
2. If you find errors or need to add to the document, click *Reject*. You are returned to the plan. Move the document back to draft status to make changes/additions.
3. If you are satisfied with the document click *Sign and Route/Notify* to electronically sign the document and route it to others for approval/notification. If the document does not require further approval, click *Sign*.
4. Enter your password and click *OK*. This serves as your electronic signature.

1. In the 'Route Document To' window, search for and select the appropriate Supervisor/Approver required to sign the plan. Additionally you have the option to route the document as a notification, after the document is finalized. Click *Add*.
2. A green check mark confirms your routing preferences. The document will be routed in this order: Supervisor > Approver(s) > Notify. **Note- If the document is routed to a Supervisor for approval, it will not be routed to other Approver(s) until the Supervisor approves the document.** Documents should not be routed to the same person as an Approver and to Notify.
3. Click *Submit*.

Route Document To

Supervisor
DIANA NORTON (010090)
Add

Add Approver
LYNN SHAW (003508)
Add

Add Team
Add

Add Staff to Notify When Final
Add

Approver	Final Approver	Notify	Title	Name
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Submit Cancel

Route Document To

Supervisor
Add

Add Approver
Add

Add Team
Add

Add Staff to Notify When Final
Add

Approver	Final Approver	Notify	Title	Name
<input checked="" type="checkbox"/>		<input type="checkbox"/>	Supervisor	DIANA NORTON (010090)
<input checked="" type="checkbox"/>		<input type="checkbox"/>	Staff	LYNN SHAW (003508)

Submit Cancel

What Happens when a Document is Rejected?

If a document is not approved as Final, the Supervisor will reject it and route it back with comments stating what needs to be added/changed/deleted (intervention not adequate, etc.) These notices are found in the *Comments* column of the 'My To Do's' Widget. View these comments directly from the widget and open the Form by clicking on the form name link in the 'Form' column.

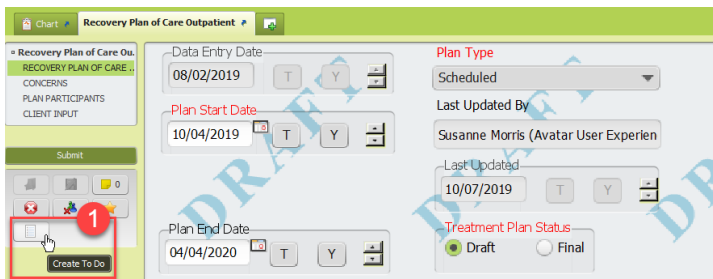
(See, *Using Document Routed myAvatar Forms- Part I-Routing Documents*, tip sheet for more information.)

To Do Message (from pg. 10)

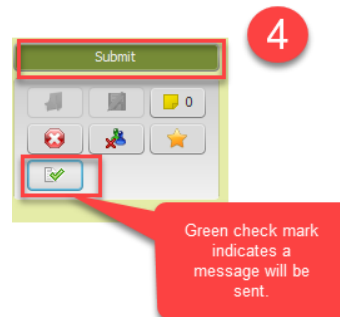
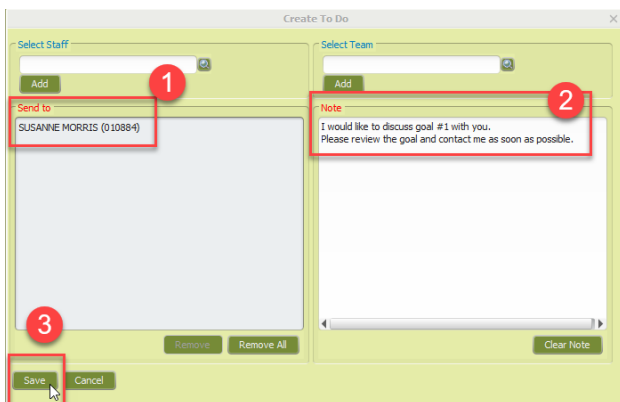
Create a To Do message to send a Draft Plan to a colleague for Review

Before submitting and routing a final Recovery Plan of Care for approval, create a To Do message to route to another staff member for review and/or questions. The message appears on the staff member's To Do list where they can review the plan, answer questions and return a message to you before finalizing. Leave the plan in Draft status and:

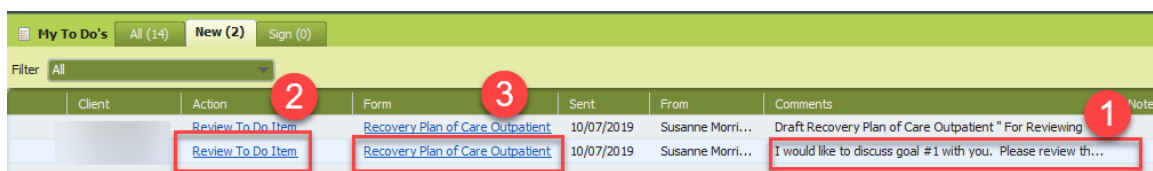
1. Select Create To Do icon.
2. In the 'Create To Do' box enter the last name of the staff member, search for and select staff member.
3. Click Add.



1. Staff member's name appears in the Send To list.
2. Enter your note in the Note section.
3. Click Save.
4. Click Submit



1. The message is sent to the specified user's My To Do's list.
2. Click on the Action column 'Review To Do Item' link to review the message.
3. Click on the Form column link to open the RPOC, review, and send a reply back to user.



Client	Action	Form	Sent	From	Comments	Note
	Review To Do Item	Recovery Plan of Care Outpatient	10/07/2019	Susanne Morri...	Draft Recovery Plan of Care Outpatient " For Reviewing	
	Review To Do Item	Recovery Plan of Care Outpatient	10/07/2019	Susanne Morri...	I would like to discuss goal #1 with you. Please review th...	